PRINTED: 11/22/2010
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100181PC	A. BUILDING _____ B. WING _____	C 11/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PLACE OF CLINTON	106 PADGETT DRIVE CLINTON, KY 42031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	INITIAL COMMENTS A complaint survey (#15394) was conducted on 11/09/10 through 11/16/10. The complaint was substantiated with a deficiency cited.	P 000		
P 115	902 KAR 20:036-4(1) SECTION 4. PROVISION OF SERVICES (1) Basic health and health related services. All personal care homes shall provide basic health and health related services including: continuous supervision and monitoring of the resident to assure that the resident's health care needs are being met, supervision of self-administration of medications, storage and control of medications, when necessary, and making arrangements for obtaining therapeutic services ordered by the resident's physician which are not available in the facility. This requirement is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to provide continuous supervision and monitoring to assure a resident's health care needs were met for one resident (#1), in the selected sample of four. On 09/13/10, the facility placed Resident #1 on every 15 minute checks, due to the resident threatening to elope from the facility. On 09/22/10, the facility documented the resident was in the bathroom for approximately five hours (7:00 PM-12:00 midnight), without actually observing the resident.	P 115	This plan of correction serves as Arbor Place of Clinton's credible allegation of compliance effective 11/17/2010. This plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement o Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law. **902 KAR 20:036-4(1) Section 4. Provision of Services** **It is the policy of Arbor Place of Clinton to provide supervision to monitor a resident to assure health care needs are being met.** **For the resident affected:** Resident #1 was returned to the facility on 9/23/10 at approximately 0115 by the local sheriff's department. No injury noted. **For residents at risk:** All residents who have been found to be an elopement risk per the elopement risk screening form have the potential to be affected.	11/17/10

Clyde Graves CMA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 11/29/10

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P 115	Continued From page 1 At 12:15 AM, the staff checked inside the bathroom and Resident #1 was not present. The facility determined the resident had climbed out a window in the resident's room. The resident was found at a car dealership in town, at approximately 1:00 AM. Findings include: A record review revealed Resident #1 was admitted to the facility, on 08/31/09, with diagnoses to include Schizophrenia, Anxiety and Depression. The resident had a court appointed Guardian. An interview with the Guardian, on 11/10/10 at 11:45 AM, revealed the resident was not allowed to leave the facility, without staff supervision. She stated the resident was unable to make safe decisions and she expected the facility to provide the necessary supervision to ensure the resident's safety. A review of the Social Worker's Note, dated 09/13/10 at 1:30 PM, revealed the resident had stated he/she was going to jump the fence if he/she did not "get a piece of ass". The Social Worker reported the resident's statement to the Assistant Director of Nursing. A review of the Fifteen Minute Check Sheets, dated 09/13/10 through 09/22/10, revealed the resident was placed on every 15 minute checks, on 09/13/10 at 1:30 PM, due threats to elope. The every 15 minutes checks were completed by staff with the documentation of the resident's location and behavior every 15 minutes. On 09/22/10, the every 15 minute check sheet revealed the resident was in the bathroom and calm, from 7:00 PM - 12:00 midnight. A review of the nurse's notes, dated 09/22/10 at	P 115	**The following measures or systemic changes were added/modified to prevent reoccurrence:** Upon notification of the resident elopement, the Administrator and DON came to the facility to conduct a search as complete a thorough investigation. It was found that the LPN charge nurse did not perform the 15 minute checks on Resident #1 as instructed and inserviced to do on 7/29/10, 8/4/10, 8/25/10, 9/17/10 and 9/18/10. In addition, the narrative charting did not match the 15 minute check documentation whereby the LPN documented the resident #1 was in the hallway or room, verbally told the investigating team the resident was in the bathroom for more than four hours, but never verified by sight or voice resident #1 whereabouts. Based on the investigation, it was found that the LPN charge nurse failed to perform her duties as assigned and counseled to do on 9/22/10 and was terminated the morning of 9/23/10. **How will the corrective actions be monitored to ensure the deficient practice will not recur?** Since resident's return on 9/23/10, additional in-servicing was provided regarding what residents are on 15 minute checks and how to properly complete a 15 minute check were done on 9/24/10, 10/11/10 and 10/25/10.	

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P 115	Continued From page 2 7:00 PM, revealed the resident was in the courtyard during a smoke break. At 7:30 PM, the resident was in his/her bedroom and at 7:30 PM, the resident was in the corner of the bedroom. At 8:00 PM, the nurse documented the resident was no longer in the corner of the bedroom, but the bathroom door was closed and the light was on. At 11:00 PM, the nurse documented the bathroom door was still closed and the light was on. The nurse had a male staff check on the resident and the resident was not in the bathroom. The building was searched and the resident was not found. At 12:00 midnight, the nurse called the ADON and was instructed to obtain a statement from everyone in the building. At 2:30 AM, the nurse documented she notified the State Guardian and made her aware the resident was back in the facility and safe. Interviews and review of statements written by Certified Nurse Aides (CNA) #1, CNA #2, CNA #3, CNA #4 and CNA #5, on 11/15/10 at 9:00 AM and at 9:30 AM, revealed the last time they saw Resident #1, on the night of 09/22/10, was immediately after the resident's smoke break, at approximately 7:20 PM. The nurse questioned them about when they had last seen the resident at approximately midnight. A search of the facility was made and the resident was not found inside the building. An interview with Licensed Practical Nurse (LPN) #1, on 11/10/10 at 9:40 AM, revealed the last time she saw Resident #1 was around 7:30 PM, after she gave the resident his/her medications. The resident went to his/her bedroom. She stated she completed the every 15 minute checks on the resident. She stated the resident had not passed her in the hall and there were no exit doors between the resident's room and where	P 115	Staff training was conducted again on 11/17/10 which entailed how and when to do a 15 minute check on a resident being: - 15 minute checks may be done by a CNA, KMA or nurse. The primary care nurse is responsible for delegation of this duty as well as verification that the checks have been completed properly as required. - The DON/ADON will review 15 minute check sheets daily Monday through Friday to verify they are completed as instructed. - The purpose of the 15 minute check is to visualize the location of the resident. If concerned with the resident's location, relocate that resident to an area of safety. - It is the duty of all staff from every department to be aware of the residents listed on the "Adventurers Club" located on the back of the break room door. - All staff from each department are responsible for responding to alarming doors when set off. - 15 minute checks can be started by the ADM, SSD, DON, ADON or on off hours, by the charge nurse on duty should a resident be exhibiting or verbalizing exit seeking behaviors. If started by the charge nurse, the administrative nurse on call must be notified as well as the physician. - Once started, 15 minute checks can be discontinued only with an MD order and approval from the ADM, DON or ADON.	

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P 115	Continued From page 3 she was located in the facility. She went to the resident's room at approximately 8:00 PM and found the bathroom door closed and the light was on. She thought the resident was in the bathroom; however, she did not knock on the door to determine whether the resident was in the bathroom. She revealed she did not want to invade his/her privacy and it was not uncommon for Resident #1 to stay in the bathroom for two hours at a time. At approximately 11:00 PM, she asked a male CNA to go into the bathroom and check on the resident and the resident was not in the bathroom. A search was conducted throughout the facility. She received a call from the police, at approximately 1:00 AM, and they informed her that the resident was in their custody and they would bring him/her back to the facility. An interview with Resident #1, on 11/10/10 at 9:50 AM, revealed he/she climbed out the bedroom window immediately after the smoke break, at 7:00 PM. The resident stated he/she was headed to another county, so he/she could get his/her rights back. The resident stated he/she turned on the wrong road and the police found him/her. Interviews with the Administrator and Director of Nursing (DON), on 11/10/10 at 9:35 AM and at 10:10 AM respectively, revealed the nurse should have knocked on the bathroom door and observed the resident at every 15 minute check intervals to ensure the resident's safety. They revealed they had no personal care home policy and procedure to address every 15 minute checks.	P 115	**How will the corrective actions be monitored to ensure the deficient practice will not recur?** The DON, ADON or administrative nurse on call will continue to review the 15 minute check sheets during regular business days and verify they are being completed properly. The ADM, DON or SSD will go over 15 minute checks and how to perform them during general staff meetings for the next three months and PRN. The process of completing a 15 minute check will be placed in each new hire packet to be reviewed and signed off on upon hire by all new employees beginning 11/17/2010.	